

**Department of Human Services
Pharmaceutical Assistance to the Aged and Disabled**

MEDICARE PART D PDP ENROLLMENT ASSISTANCE FORM

Applicant Name:			
Telephone Number:		Social Security Number:	
<p>Please choose one:</p> <p>1) <input type="checkbox"/> If I am determined eligible for PAAD, please ENROLL me in a Medicare Part D plan for which PAAD will pay the premiums. I have listed my medications below.</p> <p>2) <input type="checkbox"/> If I am determined eligible for PAAD, please DO NOT switch my current Medicare Part D Plan. I will be responsible for the premiums.</p> <p>3) <input type="checkbox"/> I am enrolled in a Medicare Advantage plan with prescription coverage.</p> <p>4) <input type="checkbox"/> I have prescription coverage through a retiree or union health plan, which has notified me NOT to enroll in a Medicare prescription drug plan. I am enclosing a copy of the notification.</p> <p><input type="checkbox"/> I CURRENTLY DO NOT TAKE ANY PRESCRIPTION DRUGS.</p>			
List the name of the pharmacy you use:			
	Drug Name	Strength	Quantity
1.			
2.			
3.			
4.			
5.			
6.			
7.			
8.			
9.			
10.			

If you need to provide additional information, please attach a piece of paper with your name, Social Security number, and additional drug names, strength, and quantity. Thank you.